Form 1147

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

Mountain Pacific Quality Health Foundation
1360 Beretania St., Ste. 500
Honolulu, Hawaii 96814

SUBACUTE/LONG TERM CARE/HOSPICE LEVEL OF CARE EVALUATION

APPLICANT INFORMATION: (Please print or Type)

1. NAME (Last, First, MI)	2. BIRTHDATE MONTH/DAY/YEAR	3. AGE	4. SEX	5. MEDICARE STATUS Part A ❑ YES ❑ NO Part B ❑ YES ❑ NO ID #	6. MEDICAID STATUS ❑ YES ID# _____ ❑ NO Date Applied _____

7. PRESENT ADDRESS (Specify Facility Name When Applicable)

Present Address is ❑ Home ❑ Hospital ❑ SNF ❑ ICF ❑ Waitlisted ❑ Care Home ❑ Other _____

8. ATTENDING PHYSICIAN

Print Last, First, MI

Phone: _____ Fax: _____

9. RETURN FORM TO: ❑ VIA FAX (Print Fax Number Below) ❑ BY MAIL (Print Address Below)

Attention _____

Phone _____ Provider Medicaid ID # _____ (Enter provider # for level of care on effective date.)

10. REFERRAL INFORMATION (To Be Completed by Referring Party)

A. CONTACT PERSON _____
B. TITLE _____
C. PHONE _____ FAX _____
D. SOURCE(S) OF INFORMATION
❑ CLIENT ❑ RECORDS ❑ OTHER _____
❑ RESPONSIBLE PERSON

Name _____
Last, First, MI

Relationship _____

PHONE _____ FAX _____

Language ❑ English ❑ Other _____

E. Requesting ❑ Nursing Facility (NF) ❑ Acute Waitlisted
❑ PACE Program ❑ Hospice
❑ Home & Community Based Services (HCBS)
❑ NHWW ❑ RACCP ❑ HCCP

11. (To Be Completed by RN or Physician)

A. ASSESSMENT DATE ____/____/____
B. ASSESSOR'S NAME

Last, First, MI

TITLE _____

SIGNATURE _____

PHONE _____ FAX _____

C. HCBS Option Counseling provided ❑ Yes ❑ No

If NO explain _____

If YES, by whom (Name) _____

Title/Relationship _____

TO BE COMPLETED BY STATE OF HAWAII MEDICAL CONSULTANT OR DESIGNEE ONLY

12. MEDICAL NECESSITY/LEVEL OF CARE ACTION

I. ❑ LOC APPROVED EFFECTIVE DATE _____
❑ SUBACUTE ❑ Level I ❑ Level II ❑ SNF ❑ ICF ❑ HOSPICE
❑ ACUTE WAITLISTED SNF from _____ to _____
❑ ACUTE WAITLISTED ICF from _____ to _____
❑ ACUTE WAITLISTED SUB-ACUTE from _____ to _____
Next Review in ❑ 1 Month ❑ 3 Months ❑ 6 Months ❑ Annual (specify mm/yy) _____ ❑ Other _____
NEXT 1147/1147a due on (date) _____
II. ❑ DEFERRED
III. ❑ DENIED
Comments _____

NOTE: THIS IS NOT AN AUTHORIZATION FOR PAYMENT OR APPROVAL OF CHARGES. PAYMENT BY THE MEDICAID PROGRAM IS CONTINGENT ON THE INDIVIDUAL BEING ELIGIBLE, THE SERVICES BEING COVERED BY MEDICAID AND THE PROVIDER BEING MEDICAID CERTIFIED AT THE TIME SERVICES ARE RENDERED. INDIVIDUAL'S ELIGIBILITY MUST BE VERIFIED BY THE PROVIDER AT THE TIME OF SERVICE.

DHS REVIEWER'S/DESIGNEE'S SIGNATURE _____ DATE _____

13. DISPOSITION

❑ Home and Community-Based Services
❑ Nursing Home Without Walls (NHWW)
❑ Residential Alternatives Community Care Program (RACCP)
❑ Level 1 _____ ❑ Level 2 _____
❑ HIV Community Care Program (HCCP)
❑ PACE Program
❑ Nursing Facility
❑ Hospice
❑ Own Home
❑ Extended Care ARCH
❑ Other _____

Comments _____

Signature Date

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APPLICANT/CLIENT BACKGROUND INFORMATION (Please print or Type)

1. NAME (PRINT Last, First, MI)

2. BIRTHDATE

3. FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS

I. LIST SIGNIFICANT CURRENT DIAGNOSIS(ES):

PRIMARY: _____

_____

SECONDARY: _____

_____

_____

_____

II. COMATOSE ❑ No ❑ Yes If "Yes," go to XIV.

III. VISION/HEARING/SPEECH

[0] a. Individual has normal or minimal impairment (with/without corrective device) of: ❑ Hearing ❑ Vision ❑ Speech
[1] b. Individual has impairment (with/without corrective device) of: ❑ Hearing ❑ Vision ❑ Speech
[2] c. Individual has complete absence of: ❑ Hearing ❑ Vision ❑ Speech

IV. COMMUNICATION

[0] a. Adequately communicates needs/wants.
[1] b. Has difficulty communicating needs/wants.
[2] c. Unable to communicate needs/wants.

V. MENTAL BEHAVIOR (circle all that apply)

[0] a. Oriented (mentally alert and aware of surroundings).
[1] c. Disoriented (partially or intermittently; requires supervision).
[2] d. Disoriented and/or disruptive.
[3] f. Aggressive and/or abusive.
[4] g. Wanders at ❑ Day ❑ Night ❑ Both, or in danger of self-inflicted harm or self-neglect.

VI. FEEDING/MEAL PREPARATION

[0] a. Independent with or without an assistive device.
[1] b. Feeds self but needs help with meal preparation.
[2] c. Needs supervision or assistance with feeding.
[4] d. Is spoon/syringe/tub fed, does not participate.

VII. TRANSFERRING

[0] a. Independent with or without a device.
[2] b. Transfers with minimal/stand-by help of another person.
[3] c. Transfers with supervision and physical assistance of another person.
[4] d. Does not assist in transfer or is bedfast.

VIII. MOBILITY/AMBULATION (check a maximum of 2 for a through d)

[0] a. Independently mobile with or without device.
[1] b. Ambulates with or without device but unsteady/subject to falls.
[2] c. Able to walk/be mobile with minimal assistance.
[3] d. Able to walk/be mobile with one assist.
[4] e. Able to walk/be mobile with more than one assist.
[5] f. Unable to walk.

IX. BOWEL FUNCTION/CONTINENCE

[0] a. Continent.
[1] b. Continent with cues.
[2] c. Incontinent (at least once daily).
[3] d. Incontinent (more than once daily, # of times _____).

X. BLADDER FUNCTION/CONTINENCE

[0] a. Continent.
[1] b. Continent with cues.
[2] c. Incontinent (at least once daily).
[3] d. Incontinent (more than once daily, # of times _____).

XI. BATHING

[0] a. Independent bathing.
[1] b. Unable to safely bathe without minimal assistance and supervision.
[3] c. Cannot bathe without total assistance (tub, shower, whirlpool or bed bath).

XII. DRESSING AND PERSONAL GROOMING

[0] a. Appropriate and independent dressing, undressing and grooming.
[1] b. Can groom/dress self with cueing. (Can dress, but unable to choose or lay out clothes.)
[2] c. Physical assistance needed on a regular basis.
[3] d. Requires total help in dressing, undressing and grooming.

XIII. TOTAL POINTS

Total Points Indicated _____

XIV. MEDICATIONS/TREATMENTS (List all Significant Medications, Dosage, Frequency and mode/ Freq. Attach Treatment sheet if more space is needed.)	Requires Supervision and/or monitoring	PRNs Only Actual
_____	❑	_____
_____	❑	_____
_____	❑	_____
_____	❑	_____
_____	❑	_____

XV. ADDITIONAL INFORMATION CONCERNING PATIENT'S FUNCTIONAL STATUS

_____

_____

_____

_____

_____

DO NOT MODIFY FORM
Legible photocopies and facsimiles will be acknowledged as original

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1. NAME (PRINT Last, First, MI)	2. BIRTHDATE

XVI. SKILLED PROCEDURES **D**=Indicate number of times per day (Check L or N if appropriate) **L**=Less than once per day **N**=Not applicable/Never

D(#)	L	N	PROFESSIONAL NURSING ASSESSMENT/CARE RELATED TO MANAGEMENT OF:
_____	❑	❑	Tracheostomy care/suctioning in ventilator dependent person.
_____	❑	❑	Tracheostomy care/suctioning in non-ventilator dependent person.
_____	❑	❑	Nasopharyngeal suctioning in persons with no tracheostomy.
_____	❑	❑	Total Parenteral Nutrition (TPN) Specify number of hours per day. _____
_____	❑	❑	Maintenance of peripheral/central IV lines.
_____	❑	❑	IV Therapy – Specify agent & frequency. _____
_____	❑	❑	Decubitus ulcers – Stage III and above.
_____	❑	❑	Decubitus ulcers – Less than Stage III; Wound care – Specify nature of ulcer/wound and care prescribed.
			_____
_____	❑	❑	Instillation of medications via indwelling urinary catheters – Specify agent.
			_____
_____	❑	❑	Intermittent urinary catheterization.
_____	❑	❑	IM/SQ Medications – Specify agent. _____
_____	❑	❑	Difficulty with administration of oral medications – Explain.
			_____
_____	❑	❑	Swallowing difficulties and/or choking.
_____	❑	❑	Stable Gastrostomy/Nasogastric/Jejunostomy tub feedings; Enteral Pump? ❑ Yes ❑ No
_____	❑	❑	Gastrostomy/Nasogastric/Jejunostomy tube feedings in persons at risk for aspiration. Specify reason person at risk for aspiration.
			_____
_____	❑	❑	Initial phase of Oxygen therapy; Oxygen therapy requiring bronchodilators.
_____	❑	❑	Complicating problems of patients on renal dialysis, chemotherapy, radiation therapy, with orthopedic traction. Circle problem(s) and describe.
			_____
_____	❑	❑	Behavioral problems related to neurological impairment. Describe.
			_____
_____	❑	❑	Other – Specify condition and describe nursing intervention.
			_____

❑ Yes Therapeutic Diet – Describe.

_____

❑ Yes Restorative Therapy: PT/OT/Speech – Circle therapy and submit/attach evaluation and treatment plan.

XVII. SOCIAL SITUATION

A. Caregiving support system is willing to provide/continue to provide care with assistance. ❑ Yes ❑ No

State assistance needed by Caregiver _____

If YES, complete B & C. If NO, go to D.

B. Name _____ Relationship _____
Last, First, MI

Address _____

_____ Phone _____

_____ Fax _____

C. Person currently has a home and can return home ❑ Yes ❑ No Residential setting can be considered as an alternative to facility. ❑ Yes ❑ No

D. Patient is appropriate for ❑ Care Home ❑ Assisted Living ❑ Hospice Residence
Check all appropriate site(s) ❑ Foster Care ❑ Shelter ❑ Other _____

XVIII. RECOMMENDATIONS/DISCHARGE PLANS

A. Requested LOC _____ D. Hospice Elected ❑ Yes ❑ No

B. Requested Effective Date of Medicaid Coverage. _____ E. Appropriate for HCBS ❑ Yes ❑ No

C. Effective Date of LOC _____

XIX. PHYSICIAN'S SIGNATURE _____ DATE _____

Physician's Name _____
Please Print

Comments _____

_____